STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155695	B. WING		07/26/2012
				ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF I	PROVIDER OR SUPPLIE	I.R		FRANKLIN ST	
RIVERSI	DE VILLAGE			RT, IN 46516	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was th	ne Investigation of	F0000	The creation and submission of	of
	Complaint IN00	_		this plan of correction does no	t
		,111 <i>1)3</i> U.		constitute an admission by this	
	a 1	2111056 0 1		provider of any conclusion set	
	*)111956-Substantiated.		forth in the statement of	
	Federal/state de	ficiencies related to the		deficiencies, or of any violation	
	allegations are o	eited at F157, F225, F309,		regulation.Due to the relative I	
	F323, F502, and	d F514.		scope and severity of this survithe facility respectfully request	
	, ,			desk review in lieu of a	is a
	Survey dates: July 22, 23, 24, 25, 26,			post-survey revisit on or after	
				August 25, 2012.	
	2012			7 lagast 20, 2012.	
	Facility number	: 003075			
	Provider numbe	er: 155695			
	AIM number: 2	00364160			
		00201100			
	Survey team:				
	Ann Armey, RN	N TC			
	,,				
	Census bed type	a·			
		··			
	SNF/NF: 85				
	Total: 85				
	Census payor ty	pe:			
	Medicare: 9				
	Medicaid: 65				
	Other: 11				
	Total: 85				
	10101. 63				
	Census: 12				
	Those deficiencies reflect state findings				
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.				
	cited in accorda	nce with 410 IAC 16.2.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

U3R811

TITLE

PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF COR		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 07/26	LETED			
NAME OF PROVID			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516						
	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
Qua		ompleted on July 31,							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U3R811

Facility ID: 003075

If continuation sheet

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PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		A. BUILDING B. WING			COMPLETED 07/26/2012	
	PROVIDER OR SUPPLIER		B. WIIW	STREET A	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST		
	DE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
F0157 SS=D	resident; consult and if known, not representative or member when the resident which the potential for rintervention; a signesident's physical status (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the resident and, if known there is a change in resident and assignment as space change in resident and the representative or when there is a change in resident and the regresentative or when the regresentati	NE/ROOM, ETC) mediately inform the with the resident's physician; tify the resident's legal an interested family ere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, estatus in either life itions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or esident from the facility as a.12(a). also promptly notify the mown, the resident's legal interested family member change in room or roommate pecified in §483.15(e)(2); or lent rights under Federal or allations as specified in					
	facility failed to a resident refused deficiency affects	ew and record review, the notify the physician when I his medication. This ed 1 of 1 resident refusal of medication, in	F01:	57	F157 – Notify of Changes (Injury/Decline/Room, etc) It is the practice of this provider to promptly notify the resident, consult with resident's physicial notify resident's legal		08/25/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U3R811

Facility ID: 003075

If continuation sheet Page 3 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLETED
		155695				07/26/2012
			B. WIN		ADDRESS CITY STATE ZIR CODE	
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE	
DI (EDO)	551/11/1405				FRANKLIN ST	
RIVERSI	DE VILLAGE			ELKHA	RT, IN 46516	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	a sample of 12.				representative or interested fa	mily
	(Resident #F)				when there is a significant	
	(Resident #1')				condition change in the reside	nt's
Finding include:				physical, mental or psychosoc	ial	
				status and/or the need to alter		
					treatment. What corrective	
	The clinical reco	ord of Resident #F was			action(s) will be accomplishe	ed
		4/12 at 10:00 a.m. and			for those residents found to	
					have been affected by the	
		ident was admitted to the			deficient practice: Resident F	·-
	facility on 3/16/1	12 with diagnoses which			physician is aware of this	
	included but wer	re not limited to, seizure			resident's continued medication	
	disorder, anxiety	and diabetes mellitus.			refusals, and will be notified of	
					any further refusals of	
	TTI I 1 2012 N	CAR OF THE C			medication. The resident has	
	<u> </u>	IAR (Medication			experienced no negative outco	
	Administration F	Records) indicated the			as a result of this finding. How	
	resident was to re	eceive Megace 400 mg			other residents having the	
	twice daily with	meals for a poor appetite.			potential to be affected by th	
		s circled as refused on at			same deficient practice will be identified and what corrective	
	_					#
		:00 p.m. doses (7/1, 3, 5,			action(s) will be taken: All residents have the potential to	ho
	11, 12, 14, 18, 20	0, 23, and 25/12) and on			affected by this finding. An all	De
	at least, 6 of 25,	8:00 a.m. doses (7/1, 2,			resident chart audit will be	
	3, 4, 5, and 24/12	2).			conducted by the Nurse	
		on the back of the MAR			Management Team to ensure	the
		ent #F also refused			physician has been notified	
					regarding resident change in	
	`	ication to reduce blood			condition and/or refusal of	
	clots) 40 mg inje	ections on 7/19/12 and			medications. What measures	
	7/21/12.				will be put into place or what	
					systemic changes will be ma	de
	There was no do	cumentation the			to ensure that the deficient	
					practice does not recur: A	
		onsulted about Resident			nursing in-service will be	
	#F's refusal of th	ne Megace and Lovenox.			conducted by the DNS/designe	ee
					on or before 8/25/12. This	
	On 7/25/12 at 9·	30 a.m., the DON			in-service will include review o	
		sing) indicated there was			the facility policy titled, "Reside	
	`	<u> </u>			Change in Condition" including	
	no documentatio	on the physician was			notification to physician regard	ing

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155695	A. BUIL B. WING			07/26/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R					
DIVED CI					FRANKLIN ST		
RIVERSI	DE VILLAGE			ELNHA	RT, IN 46516		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	notified about th	ne refusal of the Megace			resident medication refusals.	·	
		he DON indicated the			Continued compliance with		
		the facility on 7/24/12			prompt notification will be		
		-			monitored through review of		
		e resident about his refusal			nursing progress notes during	the	
	to take his medi	cation.			daily clinical meeting by the	_	
					DNS/designee. In addition, th MAR will be reviewed by the	E	
	The Resident Re	efusal of Medications,			Nurse Management Team dur	ina	
	Treatments police	cy, revised 3/2010,			the weekday clinical meeting t		
	1	DON, was reviewed on			ensure any resident medicatio		
	7/25/12, and ind	-			refusals are addressed and		
	· ·				followed up with promptly per		
		nt refuses administration			facility policy. Charge nurse to)	
	of a medication	or treatment for three (3)			review on weekend days. How	,	
	consecutive day	s, the physicianwill be			the corrective action(s) will b	oe .	
	contacted and m	ade aware of the refusals.			monitored to ensure the		
	6 Documentation	on of the physician/family			deficient practice will not red	cur,	
	notification and				i.e., what quality assurance		
		•			program will be put into place		
		endations will be charted			To ensure ongoing compliance	9	
	in the nursing p	rogress notes"			with this corrective action, the DNS/designee will be respons	iblo	
					for completion of the CQI Tool		
	This Federal tag	related to Complaint			titled, "Refusal of Medications,		
	IN00111956.				Treatments" daily for 3 weeks,		
					weekly for 3 weeks, bi-weekly		
	2.1.5(a)(2)				3 weeks and monthly for six		
	3.1-5(a)(3)				months. If threshold of 90% is	;	
					not met, an action plan will be		
					developed. Findings will be		
					submitted to the CQI Committee	ee	
					for review and follow up. By		
					what date the systemic		
					changes will be completed:		
					Compliance Date: 8/25/12.		
	I		1		I		

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Event ID: U3R811

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155695	B. WING		07/26/2012	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIEF	₹		FRANKLIN ST		
RIVERSII	DE VILLAGE			RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0225	483.13(c)(1)(ii)-(
SS=E	INVESTIGATE/F					
	ALLEGATIONS/					
		not employ individuals who				
		d guilty of abusing,				
		istreating residents by a court nad a finding entered into the				
		registry concerning abuse,				
		tment of residents or				
	•	of their property; and report				
		t has of actions by a court of				
		mployee, which would				
	indicate unfitnes	s for service as a nurse aide				
	or other facility staff to the State nurse aide					
	registry or licens	sing authorities.				
	violations involving abuse, including and misappropring and misappropring reported immediathe facility and to with State law the procedures (includer certification age). The facility must alleged violation and must prever while the investion. The results of all reported to the adesignated representations of the state of the stat	ensure that all alleged ing mistreatment, neglect, or injuries of unknown source ation of resident property are lately to the administrator of cother officials in accordance brough established uding to the State survey and ncy). I have evidence that all s are thoroughly investigated, not further potential abuse gation is in progress. I investigations must be administrator or his esentative and to other dance with State law State survey and certification				
	and if the allege appropriate corr	working days of the incident, d violation is verified ective action must be taken. ew and record review, the	F0225	F225 – Investigate/Report It i		
	facility failed to	investigate the cause of		the practice of this provider the all alleged violations involving	at	

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Event ID: U3R811

Facility ID: 003075

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		155695	A. BUILI			07/26/20	012
			B. WING	_			-
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHA	RT, IN 46516		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TF (COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	bruises, which v	vere identified on			mistreatment, neglect, or abus	se	
	dependent reside	ents. This deficiency			including injuries of unknown		
	_	esidents with incidents of			source and misappropriation of	of	
					resident property are reported		
	bruising, which were reviewed in a				immediately to the administrat	or	
	sample of 12.				of the facility and thoroughly		
	(Resident #K, #	E, #B, #C)			investigated per facility policy.		
					What corrective action(s) will be accomplished for those	'	
	Findings include	a·			be accomplished for those residents found to have been	_	
	i mamga meraak				affected by the deficient	'	
	1 771 1'' 1	1 CD :1 4 //IZ			practice: Resident #E, B, C -		
		ecord of Resident #K was			physician and families have be		
	reviewed on 7/2	5/12 at 11:00 a.m., and			updated and informed of each		
	indicated the res	sident was admitted to the			resident's current skin condition		
	facility on 10/1/	06, with diagnoses which			These residents experienced		
		re not limited to,			negative outcome as a result of		
		indness. The resident was			this finding. #K no longer resid	les	
					at facility. How other residents	s	
		e care on 8/2/11 and			having the potential to be		
	expired on 7/23/	/12.			affected by the same deficie		
					practice will be identified and		
	On 6/12/12 at 2:	29 p.m., nursing notes			what corrective action(s) will		
		was a bruise on the right			be taken: All residents are at	risk	
		•			to be affected by this finding.		
		suring 2.5 cm by 1.8 cm			Weekly Skin Assessments will		
		or warmth noted. The			completed on all residents as		
	note indicated th	ne physician and power of			as skin inspections during roubathing and shower care.	une	
	attorney were no	otified.			Shower sheets will be reviewe	.d	
	-				during weekday clinical	,u	
	On 6/21/12 at 2	46 p.m., nursing notes			meetings. Charge nurse to		
		sident presented with a			review showers sheets on		
		-			weekend days. Any new areas	s of	
	1 * *	ne left upper arm. The			bruising, discoloration will be		
		nere was no pain and the			promptly investigated and		
	resident's range	of motion was within			followed up with to determine		
	normal limits.				cause. What measures will		
					put into place or what syster	nic	
	The MDC (M:	mum Data Sat)			changes will be made to		
	The MDS (Mini				ensure that the deficient		
	Assessment, dat	ed 7/10/12, indicated the			practice does not recur: A		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITI	LDDIC	00	COMPL	ETED
		155695	A. BUI B. WIN	LDING		07/26/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1			
חויירם					FRANKLIN ST		
KIVERSI	IDE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident had sev	ere cognitive impairments			nursing in-service will be held	on	
		her extensive assistance or			or before 8/25/12. The		
	^	endent for transfer,			DNS/designee is responsible t		
					conducting this in-service. Th		
		toileting, hygiene and			in-service will include review o	f	
	bathing.				the policy titled, "Unusual		
					Occurrences for Residents &	.	
	On 7/26/12 at 1:	2:15 p.m., the DON			Visitors" with a specific focus of injuries of unknown origin sucl		
	(Director of Nu	rsing), who had just begun			bruising and discolorations.	1 43	
	employment at	5 /-			Weekly Skin Assessments will	be	
		indicated she could not			completed on all residents as		
					as skin inspections during rou		
		tion to show the bruises			bathing and shower care.		
	on the left upper	r arm and lower back,			Shower sheets will be reviewe	ed	
	were investigate	ed for causative factors.			during weekday clinical meetir		
					by the DNS/designee. Shower	s	
	2 The clinical	record of Resident #E was			sheets will be reviewed on		
		5/12 at 1:00 p.m., and			weekend days by Charge nurs	se.	
					Any new areas of bruising,		
		sident was admitted to the			discoloration will be promptly investigated and followed up v	vith	
		05 with diagnoses which			to determine cause by	VILII	
	included but we	re not limited to,			DNS/designee. <i>How the</i>		
	Alzheimer's disc	ease.			corrective action(s) will be		
					monitored to ensure the		
	On 6/11/12 at 9	:30 p.m., Resident #E was			deficient practice will not red	cur,	
		bruise on the left foot and			i.e., what quality assurance		
					program will be put into plac	e:	
	the physician or	-			The DNS/designee will be		
		1:29 a.m., nursing notes			responsible for completion of t		
	indicated the lef	t foot remained dark			CQI Audit Tool titled, "Bruises"		
	across the whole	e foot but was darker at			daily for 3 weeks, weekly for 3		
	the proximal dig	gits.			weeks, bi-weekly for 3 weeks		
	•	:12 p.m., nursing notes			monthly for 6 months to monitor ongoing compliance. If	UI	
		rays came back negative			threshold of 90% is not met, a	n	
		lays came back negative			action plan will be developed.		
	for fractures.				Findings will be submitted to the	ne	
					CQI Committee for review and		
	The Minimum I	Data Set Assessment,			follow up. By what date the		
	dated 7/10/12, i	ndicated the resident had			systemic changes will be		

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Event ID: U3R811

Facility ID: 003075

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULT: A. BUILDIN B. WING		00	(X3) DATE : COMPL 07/26 /	ETED
	PROVIDER OR SUPPLIER DE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	_	impairments and ve assistance for transfer, e and bathing.			completed: Compliance Date 8/25/12.	:	
	(Director of Nurstarted employment interviewed and find documentate bruise on the left causative factors staff who noted to employed by the staff who noted	ecord of Resident #B was 5/12 at 1:45 p.m. and ident was admitted to the /09, with diagnoses put were not limited to abetes mellitus. Skin evaluation report, :37 a.m., indicated new bruises on the left he knuckle, measuring at the tip of the finger, m by 1 cm; right forearm,					
	second area on the measuring 3 cm The Minimum D dated 6/13/12, in	he right forearm, by 2.5 cm. Pata Set Assessment, adicated the resident had					
	measuring 1.5 cr measuring 1.5 cr second area on the measuring 3 cm The Minimum D dated 6/13/12, in	m by 1 cm; right forearm, m and 1 cm distally and a he right forearm, by 2.5 cm.					

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Event ID: U3R811

Facility ID: 003075

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
111,12,12,111	or conditions	155695		LDING		07/26/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	dressing, hygiene	ve assistance for transfer,					
	diessing, nygiene	e and toneting.					
	On 7/26/12 at 12	:15 p.m., the DON					
		sing), who had recently					
	begun employme	ent at the facility, was					
	interviewed and	indicated she could not					
		on of an investigation of					
		, related to the $5/3/12$					
		ft index finger and right					
		ON indicated the staff					
		ruise were no longer					
	employed by the	facility.					
	4 The clinical re	ecord of Resident #C was					
		5/12 at 10:00 a.m., and					
		ident was admitted to the					
		/11, with a diagnosis					
		out was not limited to					
	dementia with be	ehavioral disturbances.					
		ata Set Assessment,					
	1	dicated the resident had					
	severe cognitive	-					
	required extensiv	ve assistance for transfers.					
	A late entry nurs	ing note on 7/17/12 at					
	I -	/12/12 at 2:30 p.m.,					
	· ·	nt #C had several areas					
	of bruising on the	e bilateral upper					
	extremities and b						
	extremities. The	nursing note indicated					
	the areas of bruis	sing were noted on a					
	shower sheet and	I the physician was					

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Facility ID: 003075

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PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		A. BUILDING B. WING			COMPLETED 07/26/2012		
	PROVIDER OR SUPPLIER		p. w.i.v	STREET A	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST		
(X4) ID	DE VILLAGE	TATEMENT OF DEFICIENCIES	1	ID	RT, IN 46516		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	Nurse was interv Resident #C's brown 7/12/12, were no 7/12/12 and an induction but was never confined the Corporate Norwise is identified initiated which end assessments will. The Corporate Norwise is identified initiated which end assessments will. The Corporate Norwise indicated the completed, which is the resident, to do the bruise occurred Norwise indicated to Investigation/Quesummary of the indicated the Investigation of the indicated the Investigated. The policy for Unique is the policy for Unique is of unknown investigated. The policy for Unique is the policy for Unique is of unknown investigated.	urse indicated that after a bd, a skin sheet should be assures follow up be done. urse further indicated an on/Questionnaire should nich includes finvolved in the care of etermine when and how ed. The Corporate he Event estionnaire included a investigation. 100 a.m., the as interviewed during the view and indicated all win origin should be usual Occurrences, provided by the DON, 7/26/12 at 12:30 p.m., facility would eport resident and visitor					

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Facility ID: 003075

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155695	A. BUI B. WIN	LDING		07/26/	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			1400 W	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHAF	RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	The definition of	<u> </u>		1710	·		DATE
		t included, in part:					
		UNKNOWN SOURCE					
	An injury should	be classified as an injury					
	of unknown sour	ce when both of the					
	following condit						
		the injury was not					
		person or the source of					
		not be Explained by the					
	resident AND						
		uspicious because of the					
		ry or the locationor the					
	_	es observed at one					
	*	n time or the incidence of					
		e (multiple bruises,					
	repeat bruises)."	1					
	This Federal tag	relates to Complaint					
	IN00111956.						
	3.1-28(d)						

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Event ID: U3R811

Facility ID: 003075

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155695	B. WING		07/26/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST	
	DE VILLAGE		ELKHA	RT, IN 46516	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F0309	483.25	LSC IDENTIFYING INFORMATION)	TAG	DEI TOTELLOCT)	DATE
SS=E	PROVIDE CARE WELL BEING Each resident m must provide the services to attain practicable phys psychosocial we the comprehens care. A. Based on into	e/SERVICES FOR HIGHEST aust receive and the facility e necessary care and n or maintain the highest ical, mental, and ell-being, in accordance with ive assessment and plan of erview and record review, d to ensure bowel	F0309	F309 – Provide Care/Services	- ' - ' - ' - '
	movements were provide effective 5 of 5 residents vere rev (Residents #G, #B. Based on obse	e documented in order to be bowel management for whose bowel functioning riewed in a sample of 12. EH, #I, #J, and #M)		practice of this provider to pro the necessary care and service to attain or maintain the highe practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment a plan of care. What corrective action(s) will be accomplished	vide es st nd
	comprehensively of a resident upo deficiency affect skin assessments sample of 12. (R			for those residents found to have been affected by the deficient practice: Resident (H, I, J: documentation in each resident's clinical record indicathey are having regular bowel functions. Physicians were notified for each resident and when necessary new orders were received for PRN interventions bowel aides. Resident M: have discharged from the facility.	n ates vere s for as
	movement record (Director of Nur	2 at 4:00 p.m., the bowel ds, provided by the DON sing), for Residents #G, M, were reviewed, and		been discharged from the faci How other residents having potential to be affected by the same deficient practice will i identified and what corrective action(s) will be taken: All residents have the potential to affected by these findings. A facility audit will be completed the Nurse Management Team	the ne be re be bbe bbe bby

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) M			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLI	ETED
		155695	B. WIN			07/26/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			FRANKLIN ST		
RIVERSI	DE VILLAGE				RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. Resident #H h	ad a span of 10 days,			This audit will review all reside	nt	
	between 7/9/12 a	and 7/18/12, without any			BM Records to ensure		
	bowel movemen	ts recorded. The Care			documentation is present	ما	
		12, indicated Resident			regarding each resident's bow function. It will also ensure	eı	
		or constipation due to			physician's orders are present	for	
	decreased mobile				PRN bowel aide interventions		
		ord of Resident #H was			residents not having bowel		
					movements for 3 consecutive		
		4/12 at 10:00 a.m. On			days. Any concerns identified		
	•	nile was sent to the			be addressed immediately. In addition, all new admissions w		
	1 * -	indicated Resident #H's			be reviewed to ensure that a	'111	
	"bm's (bowel mo	ovement's) are hard &	head to toe skin assessment has				
	(and) difficult fo	r her to pass"			been completed and any skin		
	On 5/10/12, an o	order was received for			issues or concerns noted on the	nis	
	Colace 100 mgs	every day.			assessment are clearly		
		3 3			documented and followed up v	vith	
	2 Resident #G h	ad a span of 16 days,			according to policy. What		
		and 7/17/12, without any			measures will be put into pla or what systemic changes w		
	bowel movemen	•			be made to ensure that the	<i>'''</i>	
					deficient practice does not		
		ed 7/24/12, indicated			recur: A nursing in-service wil	l be	
		s at risk for constipation			held on or before 8/25/12. The		
	related to decrea	•			DNS/designee is responsible f		
	_	intestinal mobility			conducting this in-service. This in-service will include review o		
	secondary to nat	ural aging.			the facility policy titled, "Bowel		
					Elimination". This in-service w		
	3. Resident #I ha	nd a span of 11 days,			also include re-education		
		and 7/17/12, without a			regarding BM documentation i	n	
	bowel movemen	, , , , , , , , , , , , , , , , , , ,			the clinical record daily by the		
		ed 7/24/12, indicated			direct care staff. In addition, a		
	· ·	at risk for constipation			resident bowel report will be completed daily by the		
	related to decrea	•			DNS/designee. Any resident		
		•			having gone 3 consecutive day	ys I	
		intestinal mobility			without a bowel movement wil	·	
	secondary to the	natural aging process.			administered a bowel aide per		
					individual resident's physician		
	4. Resident #J h	ad a span of 12 days,			order. In addition, the nurses	WIII	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155695	A. BUII B. WIN			07/26/2012
		ı	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ FRANKLIN ST	
RI//ERGI	DE VILLAGE				RT, IN 46516	
					, 70010	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		and 7/8/12, without any			be re-educated on the procedure	
	bowel movements recorded.				related to full skin assessment with all newly admitted resider	
	A Care Plan, dat	ed 7/24/12, indicated			including appropriate follow up	
	Resident #J was	at risk for constipation			documentation, measurement	
		sed mobility and			and completion of skin sheets	
		intestinal mobility			The Nurse Management Tean	
	_	-			responsible for reviewing all n	ew
	secondary to nat	urar aging.			admission documentation duri	ng
					the clinical meeting to ensure	
		nad a span of 11 days,			documentation is present,	nor
	between 7/11/12	and 7/21/12, without any			accurate and followed up with	per
	bowel movemen	ts recorded.			facility policy. Any noted concerns, omissions or errors	will
	A Care Plan, dat	red 7/24/12, indicated			be corrected and/or clarified a	
		s at risk for constipation			the time noted. <i>How the</i>	
		sed mobility, and a			corrective action(s) will be	
		- ·			monitored to ensure the	
		sis of advanced lung			deficient practice will not red	eur,
	cancer.				i.e., what quality assurance	
					program will be put into place	
					To ensure ongoing compliance	Э
	The Bowel Elim	ination policy, dated			with this corrective action, the	ible
		d by the DON (Director of			DNS/designee will be respons for completion of the CQI Aud	
	· · ·	viewed on 7/24/12 at 9:30			Tool titled, "Bowel Elimination"	
	a.m., and indicat				and the CQI Tool titled,	
	·	vements will be recorded			"Admission/Readmission	
					Procedure". Both tools will be	
	1	MR (Electronic Medical			completed daily for 3 weeks,	_
	·	record daily by the direct			weekly for 3 weeks, bi-weekly	for
	care staff.				3 weeks and monthly for 6	
	5. The DNS (Di	rector of Nursing			months. If threshold of 90% is not met, an action plan will be	
	Services)/design	ee will assign a charge			developed. Findings will be	
	nurse on a specif	fic shift to review all BM			submitted to the CQI Committee	ee
	_	ent) records on a daily			for review and follow up. By	
	basis. 6. A resident bowel report will be				what date the systemic	
					changes will be completed:	
					Compliance Date: 8/25/12.	
		e assigned charge nurse of				
	l_resident(s) who l	have not had a bowel	- 1		1	ĺ

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155695		A. BUILDING B. WING			COMPLETED 07/26/2012		
	PROVIDER OR SUPPLIER			1400 W	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	movement for 3 of given a laxative of	consecutive days. of having a bowel consecutive days, will be or stool softener, as physician, at the end of					
	interviewed and indetermined nurses documenting bown nurses were not removement record inservice was being the bowel elimination.						
	orientation tour, Resident #M was and had gangrend On 7/24/12 at 1:3 foot was observe edge of the bed. I loosened on the l	30 p.m., the resident's left d to be dangling off the The dressing had eft foot/left lower leg was exposed. The left d to be					
	indicated she had	35 p.m., LPN #12 I replaced the dressing she would rewrap					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
THIE TEAT	or condition	155695		LDING		07/26/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				FRANKLIN ST		
RIVERSI	DE VILLAGE				RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
	Resident #M's le	1t 100t.					
	The clinical recoreviewed on 7/24 p.m., and indicate admitted to the factor on 6/9/12, with do but were not limit metastasis to the the lower left ext. The Hospital Historicated Resides become more paragangrenous chan toes are very purgangrenous in nature breakdown" The facility Adm. Assessment, date resident had discossecond, third, and and scabs on the The Admission A indicated "If area alteration (wound	ard of Resident #M was 1/12 at 3:00 ed the resident was acility from the hospital diagnoses which included ited to, lung cancer with brain and ischemia of aremity. Atory, dated 6/4/12, ant #M's left foot "has inful and has developed ges. The ends of 3 of his plish and obviously ture with skin					
	and complete a s						
		cumentation the swere measured or that initiated upon admission.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		A. BUILDING		NSTRUCTION 00	(X3) DATE (COMPL 07/26 /	ETED	
	PROVIDER OR SUPPLIER		14	00 W	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	left foot was com and skin sheets ware The following ar foot and leg: "Area #1 "Unstagankle measuring shaped and prese entire area" Area #2 Unstage Achilleswhich cm which present which present O.5 cm and prese Superior Calf who 0.6 cm and prese which measures presents with blat Area #6 Unstage encompassing al presents with blat digits	geable area to left inner 6 cm X 6 cm which is "I" ents with black eschar to able area to the Left measures 4.5 cm X 2.5 ts with black eschar able area to the Left ch measures 0.5 cm X ents with black eschar able area to the Left ch measures 1.8 cm X ents with black eschar able area to Inferior Calf 1.8 cm X 0.6 cm and ck eschar able left foot 1.5 digits of left foot ck eschar encircling all the above areas were					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or confidence.	155695		LDING		07/26/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				FRANKLIN ST		
RIVERSI	DE VILLAGE				RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)		DATE
	On 7/25/12 at 0:	30 a.m., the DON					
		sing) was interviewed.					
	`	ted she could not find					
		on skin sheets and					
		ere done when Resident					
		and indicated the first					
		urements were done on					
	6/20/12.	dicinents were done on					
		ted at the time Resident #					
		skin sheets should have					
		but there was a change of					
	_	for assessing wounds.					
	starr responsible	for assessing woulds.					
	The Skin Manag	ement Program, dated					
	_	by the DON was					
	_	5/12 at 9:30 a.m., and					
	indicated, in part	•					
		oe assessment will be					
		icensed nurse upon					
	admission	the contract of the contract o					
		skin integrity will be					
		ne of two skin evaluation					
	reports dependin						
		essure woundor other					
	wound"						
	This Federal tag	relates to Complaint					
	IN00111956.						
	3.1-37(a)						
	` ´						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 07/26/2012		
	ROVIDER OR SUPPLIED	R	STREET A	ADDRESS, CITY, STATE, ZIP C FRANKLIN ST RT, IN 46516	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION		A. BUII	LDING	00		
		155695	B. WIN	G		07/26/	2012
	PROVIDER OR SUPPLIER			1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST .RT, IN 46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	.16	DATE
	REGULATORY OR 483.25(h) FREE OF ACCII HAZARDS/SUPI The facility must environment rem hazards as is po receives adequa assistance device Based on intervir facility failed to supervised while resulting in a fall This deficiency a whose fall were: 12. (Resident #M Findings include On 7/22/12 at 3:0 orientation tour, Resident #M was had gangrene of about a month ag resident had falle The clinical reco reviewed on 7/24 p.m., and indicat admitted to the fa diagnoses which limited to, lung of the brain and isci extremity.	DENT ERVISION/DEVICES ensure that the resident trains as free of accident ssible; and each resident te supervision and tes to prevent accidents. ew and record review, the assure a resident was to on the commode the without injury. Infected 1 of 6 residents, treviewed, in a sample of the commode to p.m., during the RN #11, indicated to receiving hospice care, this left foot and had a fall to RN #11 indicated the ten off the commode. The resident #M was the resident was the resi	F03	TAG	CROSS-REFERENCED TO THE APPROPRIA	on/ is is ident ie; ed M: nt d I ng il to i will of er e n	
	The MDS (Minii	mum Data Setj			for any resident requiring it.	0	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	OO COMPLETED		
		155695	B. WIN			07/26/2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			FRANKLIN ST		
RIVERSI	DE VILLAGE				RT, IN 46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
	Assessment, date	ed 6/26/12, indicated the			What measures will be put in	ito	
	resident had mod	derate cognitive			place or what systemic		
	impairments and	required extensive			changes will be made to ensure that the deficient		
	assistance for tra	insfers and toileting.			practice does not recur: A		
		8			nursing in-service will be held	on	
	The fall care plan	n dated 6/20/12			or before 8/25/12. The		
	_	ident was at risk for falls			DNS/designee is responsible f	or	
					conducting this in-service. Thi		
		. The care plan included			in-service will review the facilit	•	
	the following int				policy titled, "Fall Management	t	
	call light in reacl	h,			Program". This in-service will also include review of the care		
	environmental cl	hanges as needed,			plan process and importance of		
	non skid foot we	ear, and			adherence to established care		
	personal items in	reach.			plans and safe practices in		
	*	eplan intervention was			regards to providing appropria	te	
		icated "do not leave			level of assistance and/or		
					supervision for all transfers. A		
		t or bedside commode			change in resident transfer ned		
	unattended."				is identified during daily clinica	ıl	
					meetings. Changes are communicated to direct care s	toff	
	A Fall Event Rep	port, dated 7/1/12 at 9:10			promptly through updates to ca		
	a.m., indicated R	Resident #M had been on			plans and Nurse Aide Assignm		
	the commode an	d was found lying on left			Sheets. Each shift, Charge		
		bow next to his bed. The			Nurse to do rounds to ensure		
	_	rt indicated the fall was			C.N.A. Assignment Sheets are	;	
	•	that the resident was not			being followed which includes		
	injured.	that the resident was not			resident not being left alone or	ı a	
	mjurcu.				bedside commode. How the corrective action(s) will be		
	0 7/0/10 14 5	T. IDT			monitored to ensure the		
	On 7/2/12 at 4:5:	_			deficient practice will not rec	eur,	
		y Team) note indicated			i.e., what quality assurance	·	
	the resident "slid	off bed side commode			program will be put into plac	e:	
	and was heard ye	elling for help. CNA			To ensure compliance with the	se	
	observed Reside	nt laying on floor.			corrective actions, the		
		ted he started to fall			DNS/designee will complete th	ie	
	` ′	slipped off the bedside			CQI Audit Tool titled, "Fall	·e	
	_	nded on his left knee"			Management" daily for 3 week weekly for 3 weeks and month		
		nucu on ms ich knee			weeks and month	ıy	

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Event ID: U3R811

Facility ID: 003075

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155695	A. BUI B. WIN	LDING IG		07/26/	
	n o v v n n n o		b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1400 W	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHAI	RT, IN 46516		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		dicated "When resident		_	for 6 months. If threshold of 9	0%	
	is placed on beds	side commode or in			is not met, an action plan will be	pe	
	bathroom that nu	rsing staff will be with		developed. Findings will be submitted to the CQI Committee			
	resident at all tin	nes"			for review and follow up. By		
	0.7/06/1010	4. 501			what date the systemic changes will be completed:		
		:30 a.m., the DON sing), indicated Resident			Compliance Date: 8/25/12.		
	`	ave been left alone on the					
		OON indicated staff were					
	educated and the	resident's care plan was					
	updated after the	incident.					
	_	relates to Complaint					
	IN00111956.						
	3.1-45(a)(2)						
	3.1-43(a)(2)						

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Event ID: U3R811

Facility ID: 003075

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIJII DING	A. BUILDING 00 COMPLE		
		155695	B. WING		07/26/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		V FRANKLIN ST		
RIVERSI	DE VILLAGE			ART, IN 46516		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0502 SS=D	483.75(j)(1) PROVIDE/OBT	AIN LABORATORY				
	SVC-QUALITY/					
		t provide or obtain laboratory				
		t the needs of its residents.				
	The facility is re timeliness of the	sponsible for the quality and e services.				
	Based on observ	vation, interview and	F0502	F502 – Administration It is th	ne 08/25/2012	
		he facility failed to ensure		practice of this facility to provid		
	· ·	icked up a stool specimen		or obtain laboratory services to		
	after it was obta	• •		meet the needs of the residen The facility is responsible for t		
		affected 1 of 1 resident		quality and timeliness of these		
	1			services. What corrective		
		nad a stool specimen	action(s) will be accomp		ed	
	ordered, in a sar	nple of 12. (Resident #D)		for those residents found to		
				have been affected by the		
	Findings include	2 :		deficient practice: Resident L		
				has been discharged from the		
	On 7/22/12 at 6:	30 p.m., Resident #D was		facility. How other residents		
	observed in the	assisted dining room. The		having the potential to be affected by the same deficien	nt	
	resident would s	shake her head, no, when		practice will be identified and		
		give her bites of the food.		what corrective action(s) will		
		sive her ones of the root.		be taken: Any resident requiri		
	The clinical rese	ord of Resident #D was		laboratory services has the		
				potential to be affected by this		
		3/12 at 3:00 p.m. and		finding. A facility audit will be		
		sident was admitted to the		completed by the Nurse	i+	
		07, with diagnoses		Management Team. This aud will review all residents with la		
	including but no	ot limited to, vascular		orders to ensure all labs and		
	dementia, and d	iabetes mellitus.		specimens are obtained and		
				picked up by the lab as ordere	ed.	
	On 7/20/12 at 9:	45 p.m., nursing notes		Physician orders are reviewed		
		nurse was notified by		the Nurse Management Team		
	· · · · · · · · · · · · · · · · · · ·	Nursing Assistant) that		All physician orders related to	h -	
	`	rrhea and had a foul		labs will be cross checked to t	ne	
				Lab Requisition Form by the Medical Records Clerk/design	66	
		sing note indicated the		to ensure labs and specimens		
	nurse assessed t	he resident's stool, and		obtained and sent to the lab for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O	COMPLETED
155695 B. WING	07/26/2012
STREET ADDRESS, CITY, STATE, ZIP CO	ODE
NAME OF PROVIDER OR SUPPLIER 1400 W FRANKLIN ST	
RIVERSIDE VILLAGE ELKHART, IN 46516	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR. PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO	
CROSS-REFERENCED TO THE AP	PPROPRIATE
TAG REGULATOR ON ESC IDENTIFICAÇÃO (MAINTION)	DATE
notified the physician. processing as ordered. discrepancies will be co	
and/or clarified when no	l l
Physician orders, dated 7/20/12, What measures will be	
indicated, the following: place or what systemic	-
a stool specimen was to be obtained and changes will be made	to
the physician was to be notified of the ensure that the deficie	ent
results: practice does not recu	
nursing in-service will be	
administered every day for five days; and DNS/designee is responsible the physician was to be notified if	
in service will include re	
diarrhea persisted. the procedure related to	l l
labs and specimens and	•
A microbiology laboratory requisition emphasize the importar	
form, dated 7/20/12 at 8:30 p.m., ensuring labs and speci	
indicated the resident's stool was to be obtained and sent to the	l l
processing timely and a	
tested for Clostridium difficile antigen ordered. All physician of toxins A and B.	
checked to the Lab Reg	
Form by the Medical Po	- I
The July 2012 MAR (Medication Clerk/designee to ensur	
Administration Record) indicated the and specimens are obtained and specime	
stool specimen was obtained on 7/20/12. sent to the lab for proce	_
ordered. How the corre	
Nursing notes indicated the resident had action(s) will be monit	l l
no further de commente de la galacte el surtil	
7/23/12 at 9:39 a.m. will not recur, i.e., wha	
into place: Ongoing col	
On 7/23/12 at 3:15 p.m., LPN #10, who with this corrective action	
bod obtained the steel greeiner, year	facility CQI
had obtained the stool specimen, was Program. The DNS/des	
interviewed. LPN #10 indicated she had be responsible for comp	
obtained the specimen on 7/20/12, but the the CQI Tool related to	
laboratory never picked up the specimen. Services daily for 3 weeks and	·
for 6 months. If thresho	
On 7/23/12 at 5:33 p.m., nursing notes is not met, an action pla	
indicated the physician was notified that developed. Findings wi	

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PRINTED: 08/14/2012 FORM APPROVED OMB NO. 0938-0391

-	N OF CORRECTION IDENTIFICATION NUMBER: 155695 A. BUILDING B. WING		COMPLETED 07/26/2012			
	PROVIDER OR SUPPLIER DE VILLAGE		1400 W	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	and the physiciar resident's current included poor ora vital signs. The n indicated the phy	en had not been obtained in was updated on the condition, which al intakes and a change in cursing notes further esician ordered Resident It to the hospital for		submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 8/25/12.	ee	
		32 p.m., nursing notes dent was transferred to was subsequently				
	contacted the lab acknowledged th about the stool sp they offered no e	sing) indicated she had				
	This Federal tag IN00111956. 3.1-49(a)	relates to Complaint				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00		COMPL	COMPLETED		
		A. BUILDING		07/26/	07/26/2012		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t					
RIVERSIDE VILLAGE			1400 W FRANKLIN ST ELKHART, IN 46516				
		TATEMENT OF DEFICIENCIES		<u> </u>	,	1	(27.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F0514	483.75(I)(1)	LISC IDENTIFY TING INFORMATION)		IAG	,		DATE
SS=E	RES						
00-L		//PLETE/ACCURATE/ACCE					
	SSIBLE						
	The facility must	maintain clinical records on					
		accordance with accepted					
	l •	ndards and practices that are					
		ately documented; readily					
	accessible; and	systematically organized.					
	The clinical reco	rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
	l •	reening conducted by the					
	State; and progre	ess notes.					
	Based on intervi	ew and record review, the	F05	14	F514 – Records –		08/25/2012
	facility failed to	document baths/showers.			Completed/Accurate/Accessi		
	This deficiency a	affected 6 of 8 residents,			It is the practice of this provide to maintainclinical records on	der	
	whose bath recor	rds were reviewed, in a			each resident in accordance w	vith	
	sample of 12.				accepted professional standar		
	_	I, #C, #E, #G, #J)			and practices that are complete;		
	(,	-,,,,			accurately documented; readily	у	
	Findings include:				accessible; and systemically		
	1 mamgs merade	•			organized and that contain sufficient information to identify	.,	
	On 7/2//12 at 11	100 a m. The DON			the resident. What corrective	у	
		:00 a.m., The DON			action(s) will be accomplished	ed	
	· ·	sing) was interviewed			for those residents found to		
		ey did not have a specific			have been affected by the		
	1 ^ -	ers/baths, but they were			deficient practice: Resident E		
		wice weekly to each			C, E, G, & J: have been receive	•	
	resident. The Do	ON indicated CNAs			routine shower/bath care. The	ese	
	(Certified Nursin	ng Assistants) were to fill			residents experienced no negative outcome as a result of	nf .	
	out a shower she	et every time a shower or			this finding. <i>How other</i>	<i>-</i> 1	
		even if it was refused.			residents having the potentia	al	
		ted she checked the			to be affected by the same		
		r individual residents			deficient practice will be		
					identified and what corrective	е	
	against the snow	er schedule for July 2012			action(s) will be taken: All		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
	155695		B. WING			07/26/2012	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			FRANKLIN ST		
RIVERSIDE VILLAGE				RT, IN 46516			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COR		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	and many of the	requested shower/bath			residents have the potential to		
	sheets, for depen	ndent Residents #B, #I,			affected by this finding. Show	er	
	#C. #E. #G. and	#J, were missing. The		sheets will be reviewed by the Nurse Management Team duri			
		_					
	DON indicated, as a result, she had no documentation the showers or baths were given. She indicated she felt the			the clinical weekday meeting compared to the daily shower		iiiu	
					schedule. Any resident noted to		
	~				have missing documentation		
	baths/showers were provided, but the staff				related to shower/bath care wi	II	
	failed to docume	ent them.			be investigated and		
					corrected/rectified at the time		
	On 7/26/12 at 11	:25 p.m., The July 2012,			noted. What measures will be		
	Shower/Bath she	eets for Residents #B, #I,			put into place or what system changes will be made to	nic	
	#C. #E. #G. and	#J were reviewed with			ensure that the deficient		
		dicated the following:			practice does not recur: A		
	the Bort and me	diedied the following.			nursing in-service will be held	on	
	D :1 //D1 1	C 1 // /1 1 /			or before 8/25/12. The		
		four shower/bath sheets			DNS/designee is responsible f	or	
	missing and as a result, no documentation			conducting this in-service. This			
	showers or baths	s were given or refused on			in-service will include review o		
	7/4, 7/7, 7/11, ar	nd 7/14/12.			the facility procedure related to		
	Resident #I had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/9, and 24/12				resident care including shower and bathing assistance. This	S	
					in-service will emphasize the		
					importance of daily		
					documentation by direct care s	staff	
					related to showers and bathing		
					care. Charge Nurses will be		
					responsible for ensuring that		
		four shower/bath sheets			showers/baths are given as		
	_	result, no documentation			scheduled and that appropriate	9	
	showers or baths	s were given on 7/4, 7/7,			documentation has been completed prior to the conclus	ion	
	7/11, and 7/14/1	2			of each shift. Shower sheets v		
					be reviewed by the Nurse	"	
	Resident #E had	three shower/bath sheets			Management Team during the		
					clinical weekday meeting and		
	missing and as a result, no documentation showers or baths were given on 7/6, 7/10,				compared to the daily shower		
		were given on //o, //10,			schedule. Any resident noted	to	
	and 7/13/12.				have missing documentation		
					related to shower/bath care wi	II	

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	of correction identification number: 155695	A. BUILDING B. WING	COMPLETED 07/26/2012
RIVERSII (X4) ID PREFIX	ROVIDER OR SUPPLIER DE VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516 ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION (X5) D BE COMPLETION
TAG	Resident #G had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/19 and 7/23/12 Resident #J had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/10 and 7/24/12. All of the residents whose bath records were reviewed, had severe to moderate cognitive impairments and required extensive assistance for bathing. This Federal tag relates to Complaint IN00111956. 3.1-50(a)(1)	be investigated and corrected/rectified at the t noted. How the correctin action(s) will be monitor ensure the deficient practival into place: The DNS/desi will be responsible for confidence of the CQI Tool titled, "Accommodation of Need for 3 weeks, weekly for 3 and monthly for 6 months monitor for ongoing complist threshold of 90% is not action plan will be develop Findings will be submitted CQI Committee for review follow up. By what date to systemic changes will be completed: Compliance It 8/25/12.	ime ve ed to ctice quality be put gnee npletion s" daily weeks to liance. met, an bed. I to the v and he e

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